PATIENT HEALTH RECORD

Date:

...The following information is essential to provide you with quality dental health care... Thank you...

Name: (Last,First,Middle Initial)	Home Phone:	Work Phone:	Cell Phone:

Home Address:	City:	State:	Zip:

Age:	Birthdate:	E-mail Address:	Name of Physician:

Have you had:

Check each box if the answer is "YES"; if "YES" explain below

- ❑ Rheumatic Heart Disease
- ❑ Heart Murmer
- ❑ Heart Attack / Surgery, Angina
- ❑ Anemia, Excessive Bleeding
- ❑ Irregular Heart Beat, Pacemaker
- ❑ Breathing Problems, Asthma, T.B.
- ❑ Cancer, Chemo / Radiation Therapy
- ❑ Diabetes
- ❑ Hepatitis, Jaundice, Liver Disease
- ❑ Abnormal Blood Pressure
- ❑ Artificial Joint Replacement
- ❑ Kidney Problems, Dialysis
- ❑ Stroke, Convulsions, Fainting
- ❑ Arthritis, Rhuematism
- ❑ Venereal Disease, A.I.D.S.
- ❑ Stomach or Intestinal Disease

Other health complications not listed above:
Have you ever had a major operation? If yes, describe.
Are you currently taking any medication? If yes, please list each medication and for what reason or condition?
Are you allergic to: ❑ Latex ❑ Penicillin ❑ Codeine ❑ Local Anesthetic ❑ Other Medications ____________

Authorization:

I authorize the dentist to release health information about me and information about my dental treatment to other health professionals and to insurance companies.

Person completing this form:

Signature:	Date:

If this form was not completed by the patient, please provide the following:

Printed name of person completing this form:	Relationship to patient: